MDR Tracking Number: M5-04-0886-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 11-24-03.

The IRO reviewed office visits, ROM, temperature gradient studies, physical performance test (muscle testing) from 3-3-03 to 5-7-03.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. The IRO agreed with the previous adverse determination that the office visits, temperature gradient studies and physical performance test (muscle testing) **were not** medically necessary. The IRO concluded that the ROM testing on 3-4-03 **was** medically necessary. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 1-30-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
2-28-03 4-3-03 4-7-03 4-8-03 4-10-03 4-11-03 4-14-03 4-15-03 4-18-03 4-25-03 4-28-03 5-12-03 5-13-03 5-14-03 5-21-03 5-22-03 5-23-03 6-9-03 6-12-03 6-16-03	99213	$48.00 x 20 days	$0.00	F, 214	$48.00	Rule 134.307(g)(3)(A-F); MFG Med. GR I A 4	MFG Medicine ground rule states that the patient shall be re-examined by the treating doctor within 60 days of the initiation of treatment by the HCP. Thereafter, if treatment by the HCP is to be continued, re-examination by the treating doctor shall occur at least monthly. Relevant information supports delivery of service. Therefore, recommend reimbursement for 2-28-03, 4-3-03, 5-12-03 and 6-9-03 x $48.00 =$192.00.
3-3-03 3-17-03	97750-MT (2) 97750-MT (1)	$86.00 $43.00	$0.00	N, 225	$43.00 per body area	Rule 134.307(g)(3)(A-F)	Relevant information supports documentation criteria and delivery of service. Recommend reimbursement of $43.00 x 3 = $129.00.
4-16-03	97750	$559.00	$0.00	F, 281	$43.00 ea 15 min		Relevant information did not include a written report as required. No reimbursement recommended.
4-7-03	95851	$36.00	$0.00	No EOB	$36.00 ea extremity		Requestor failed to submit relevant information to support delivery of service. No reimbursement recommended.
4-29-03 4-30-03 5-5-03 5-6-03 5-7-03	97530	$140.00 x 5 days	$0.00	F, 270	$35.00 ea 15 min		Relevant information supports delivery of service. Recommend reimbursement of $140.00 x 5 = $700.00.
7-3-03	99080-73	$15.00	$0.00	N, 227	$15.00	Rule 129.5	Relevant information did not support documentation criteria or delivery of service.

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$ (Max. Allowable Reimbursement)	Reference	Rationale
2-28-03 3-3-03 to 3-7-03 3-10-03 to 3-14-03 3-17-03 to 3-21-03 3-24-03 to 3-27-03 3-31-03 4-3-03 4-7-03 4-8-03 4-10-03 4-11-03 4-14-03 4-16-03 4-29-03 4-30-03 5-5-03 to 5-7-03	97110	$140.00 x 33 days $35.00 x 1 day	$0.00	N, 225	$35.00 ea 15 min	Rule 134.307(g)(3) (A-F)	Relevant information does not support documentation criteria per the **RATIONALE** below. No reimbursement recommended.
TOTAL							The requestor is entitled to reimbursement of $829.00.

RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one". Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation.

The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable for dates of service 2-28-03 through 6-16-03 in this dispute.

This Order is hereby issued this 3rd day of June 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division

NOTICE OF INDEPENDENT REVIEW DECISION

Date: May 25, 2004 **AMENDED DECISION**

MDR Tracking #: M5-04-0886-01
IRO Certificate #: 5242

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a Chiropractic reviewer who has an ADL certification. The reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History
It appears the claimant was lifting a book cart off a truck on ___ when he allegedly suffered low back injury. The cart reportedly weighed about 30-40 pounds and he was lifting it over a groove in the truck and apparently suffered low back injury. The initial chiropractic visit of 2/28/03 seemed to reveal the claimant had suffered a cervical, thoracic, and lumbar sprain/strain injury. The chiropractic diagnoses were listed to be lumbar disc disorder with myelopathy, lumbar nerve root compression, lumbar sprain/strain and cervical sprain/strain. The objective documentation does not support that the injury was to the extent suggested by the diagnoses from the chiropractor. The claimant has undergone chiropractic care from approximately 2/28/03 through the end of June 2003. The treating chiropractor gave the claimant 5% whole body impairment rating and released the claimant to MMI as of 7/3/03. At that time the claimant was still complaining of significant low back pain and the claimant reported he was having low back pain 70% of the time; however, his neck and mid-back pain were much improved. The claimant underwent several range of motion and muscle testing evaluations throughout the chiropractic treatment. He also underwent temperature gradient studies. The claimant did undergo an MRI of the lumbar spine which reportedly revealed a central disc herniation that was felt to be noncompressive on the cord and nearby nerve root structures at the L4/5 level. The chiropractic documentation was extensively reviewed and the explanation of benefits review documentation was also extensively reviewed. It appears the carrier did indeed reimburse the treating chiropractor for manual traction, myofascial release and joint mobilization on numerous occasions. The carrier also reimbursed the chiropractor for therapeutic activities and therapeutic exercises on numerous occasions.

Requested Service(s)

Office visits, range of motion and muscle testing measurements and studies, temperature gradient studies and physical performance tests rendered from 3/3/03 through 5/7/03.

Decision

Date	CPT Codes Approved	CPT Codes NOT Approved
3/3/03		99213
3/4/03	95851	99213
3/5/03		93740, 99213
3/6/03		99213
3/10/03		99213
3/11/03		99213
3/12/03		99213
3/17/03		99213, 97750
3/18/03		All
3/19/03		99213
3/20/03		All
3/24/03		99213
3/25/03		93740,99213
3/26/03		All
3/31/03		99213
4/3/03		97750
4/7/03		99213, 95851
4/8/03		99213
4/10/03		All
4/14/03		99213
4/15/03		93740, 99213,
4/16/03		All
4/28/03		99213
4/29/03		99213,
4/30/03		95851
5/5/03		99213
5/6/03		99213

Rationale/Basis for Decision

The chiropractic documentation as of 3/17/03 did start to better document the exact type of the exercises performed. I agree with the carrier and find that the temperature gradient studies which were billed as 93740 were not medically necessary. These particular studies did not contribute to or enhance the treatment plan or prognosis of the claimant and would not be considered reasonable or medically necessary. None of the services billed as 93740 would be considered reasonable or medically necessary. I agree with the carrier and find that the amount of office visits billed were not medically necessary. It is reasonable and customary that while a claimant is undergoing a physical therapy program it is not necessary to see the chiropractor 4 or 5 times per week. In fact once per week office visits would be more than sufficient for monitoring purposes and to make any needed adjustments in the treatment plan and to plan for any referrals that are needed. The carrier did pay for joint mobilization and there was no need for the claimant to see the chiropractor 4 and 5 times per week.

The claimant's condition was also documented to be essentially unchanged and the same exact findings were found on virtually every visit, therefore the medical necessity of the voluminous office visits needs to be highly questioned. I agree with the carrier and find that the muscle testing and range of motion studies billed as 97750 and 95851 were not medically necessary. These tests were done every 2 weeks and this would be considered an excessive frequency. The only exception to this would be the 95851, which was billed and rendered on 3/4/03. These would be medically necessary in my opinion in order to gain a baseline study regarding the claimant's range of motion and lumbar strength. I also found it interesting that on the 3/24/03 chiropractic follow up visit the claimant's cervical range of motion was reported as normal and the upper extremity and lower extremity muscle testing was also reported as normal. If this were the case, then there would be no need for further testing of these areas except for perhaps a final physical performance evaluation or FCE when the claimant was released to MMI on 7/3/03. I also found it interesting that on 3/24/03, even though the claimant's range of motion and muscle strength testing was reportedly performed, there was no documentation that a muscle test or range of motion code was used. Therefore, testing or evaluation for these range of motion and muscle strength tests would be part of the normal office visit and should be part of the billing for a normal office visit. Again, the range of motion of the cervical spine and upper and lower extremity muscle tests were reported as normal on 3/24/03, therefore I do not see the need for testing every 2 weeks as occurred in this particular case.